Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29490
SAN ANTONIO TX 78229

Respondent Name
WC SOLUTIONS

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4- 13-0481-01

MFDR Date Received
OCTOBER 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Insurance rep stated services which were provided were covered under worker's compensation claim. We received a phone call from Kasey. (Edwards Claims Admin rep) She provided Edwards Claims Worker's Comp information.. [sic] We received an EOB denying our claim based on no authorization. We received an EOB denying our request for reconsideration. We attempt to contract Laurie Hanson. (claims adjuster) I wanted to know why the claim was denied for no auth if we were contacted by Edwards claims Insurance & asked to bill claim for date of service 2/21/12 to Edwards claims. I left a voice message & no one has returned by call."

Amount in Dispute: $17.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 72100, for date of service 2/21/12, was denied on reconsideration with the ANSI reduction code of 197 with Explanation of Benefits (EOB) comments of: '*Per the ODG, plain films of the lumbar spine for treatment of low back strain are not recommended. Therefore, this study requires preauthorization*. Please see Attachment 1 – ODG recommendations for Low back – Lumbar & Thoracic (Acute & Chronic) Radiology (x-rays). In this case, there has been no Lumbar spine trauma that would indicate imaging to the lumbar spine. The claimant's account of the accident further documents and clarifies that there was no true trauma to the Lumbar spine. (Please see Attachment 2, transcribed claimant statement)'"

Response Submitted by: Starr Comprehensive Solutions, Inc., PO Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2012	CPT Code 72100	$17.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization
4. 28 Texas Administrative Code §137.100 sets out the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 193 – Original payment decision is being maintained. This claim was processed the first time.
   - 197 – Per the ODG, plain films of the lumbar spine for treatment of a low back strain are not recommended. Therefore, this study requires preauthorization.

Issues

1. Did the medical services provided to the injured employee require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied the services in dispute per the ODG and absence of preauthorization using denial code 197 – "Payment denied/reduced for absence of precertification/authorization." and 197 - "Per the ODG, plain films of the lumbar spine for treatment of a low back strain are not recommended. Therefore, this study requires preauthorization." According to 28 Texas Administrative Code §28 Texas Administrative Code 137.100(e), which states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017." 28 Texas Administrative Code 137.100(d)(1-2) states, "The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: the treatment(s) or service(s) were provided in a medical emergency; or the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.100 of this title."

   In accordance with 28 Texas Labor Code §134.600(c)(1)(A), which states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur: an emergency, as defined in Chapter 133 of this title." Per 28 Texas Administrative Code §133.2(a)(4)(A), "A medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the documentation finds that the injured worker presented to the emergency room on February 21, 2012; however, the clinical history indicates low back pain; no other information is provided to support a medical emergency as defined above.

2. The Division finds that documentation does not support a medical emergency; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.